South Gloucestershire Safeguarding Children Board News and Research

Quarter Three

Domestic Abuse

Serious Case Reviews:

Combined domestic homicide review and serious case review: Ms AB aged 45 years: Child D aged 22 months: each killed in Hackney in March 2014 *Author: Bill Griffiths LSCB: City and Hackney SCB (2016)*

Death of 22-month-old Child D and her mother, Ms AB, in March 2014. Child D's father and Ms AB's ex-partner, Mr YZ, was convicted of their murder and sentenced to life imprisonment. In February 2014, Ms AB reported serious domestic abuse to the police. Prior to this, there were no records of Ms AB and Child D having contact with any agencies other than universal health services. Father had a previous conviction for drug offences and was known to drug and alcohol services and the Probation Service. Issues identified include: Ms AB's disclosure to the police of Mr YZ's threat to kill her and her three children (Child D's siblings aged 14 and 15) did not result in a thorough investigation and action to protect them; there were missed opportunities to refer the case to children's services who could have made their own risk assessment of potential harm to the children.

Serious case review: Child BS *Author & LSCB Unnamed (2016)*

Death of a 2year old girl in 2016 in hospital as the result of multiple injuries. Child died from a serious brain injury sustained whilst in the sole care of mother's new partner. The partner was charged with murder and was sentenced to nine years' imprisonment. The mother was placed on police bail. Family were known to universal services only. Child had a bruise to the face the week before the incident which was recorded by the nursery. Issues identified include: the significant impact of the change in the mother's relationship on her children's safety, a lack of robust recording by the nursery following an injury to Child BS and a lack of robust evidence behind Ofsted's positive rating of the nursery's safeguarding provision leading to a misplaced confidence in their procedures. Also identifies examples of good practice including: supportive and timely postnatal contacts with child health services and contact from the local Children's Centre to offer a range of community services following the birth of both children. Recommendations include: develop common guidance and supporting documentation for local nursery providers; develop public awareness of domestic abuse and the risks to children at the points of parental separation and newly formed relationships; and get assurance from Ofsted that the lessons of the review have been acted on and disseminated throughout the organisation.

Linked Research & Resources:

Working with perpetrators of domestic violence: An article in Community Care reports on the Growing Futures project in Doncaster which works with parents who have abused their partners through violence or controlling behaviour.
Source: Community Care **Date:** 19 January 2017

Domestic abuse resource for health professionals: The Department of Health (DoH) has published a resource looking at how health professionals in England can support adults and young people aged over 16 who are experiencing domestic abuse, and dependent children in their households. The resource covers: the legal and policy contexts of domestic abuse; information for commissioners and service providers; and what health practitioners need to know. Annexes include: examples of domestic abuse behaviours; and risk identification tools for adults and dependent children and young people.
Source: DoH **Date:** 08 March 2017 **Further information:** Responding to domestic abuse: a resource for health professionals (PDF)

Domestic Violence and Abuse Training in South Gloucestershire: There is a new training pathway for inter-agency Domestic Violence and Abuse training in South Gloucestershire. You can build up your knowledge and skills from an introductory e-learning module through to the level of training that you need to fit your job role. There are lots of course dates available in 2017-18
Further Information: http://learning.southglos.gov.uk

Mental Health

Serious Case Reviews:

Serious Case Review: Child O *Author: Sian Griffiths LSCB: Lancashire SCB (2016)*

Death of 22-month-old Child O at the hands of their mother who also killed herself in summer 2014. A post-mortem concluded mother and child died of carbon monoxide poisoning. Parents were separated, and mother and Child O had since moved to a number of areas around the country. At the time of their death in Lancashire, they were not known to any statutory or other agencies within the county. Father had made an application for contact with Child O and a Cafcass children's guardian was working with the family. Mother had made unsubstantiated allegations to Devon and Cornwall police of domestic violence and sexual abuse against Child O's father. The coroner's inquest concluded there was no substance to the mother's belief that she was being pursued by Child O's father and he had acted appropriately throughout. Mother had a history of possible post-natal depression and personality problems; and giving misleading information to statutory services to conceal the whereabouts of herself and Child O. Findings include: there were organisational weaknesses in the approach to working constructively and proactively with fathers; professionals need to be encouraged to balance respect for women who talk about domestic abuse with appropriate scepticism and curiosity where allegations are denied. Makes multi-agency recommendations including developing knowledge and awareness of the nature of homicide in the context of parental conflict.

A serious case review: 'Child AB' *Author & LSCB Unnamed (2017)*

Life threatening assaults of child by mother, followed by mother's suicide attempt, in 2014 and 2015. On two occasions Child AB, a junior school-aged child, was subject to life threatening assaults by attempted suffocation and strangulation by the mother, who then attempted to commit suicide. Mother was charged with attempted murder and placed on bail, and Child AB became subject to child protection investigation and child in need plan, and was placed with father, with contact arrangements managed by children's social care. After a second assault mother was charged and convicted of child neglect. No indication of child abuse prior to the first event. Maternal history of: mental illness, self-harm, disclosed attempts to harm husband and attempted suicide; disclosure of emotional abuse in marriage. Key issues identified include: management of screening for maternal mental health and domestic abuse not fully embedded in practice; lack of direct questioning regarding thoughts to harm others and extended suicide in primary care and mental health services; ineffective use of child protection processes; lack of a joined-up process of multi-agency assessment and management of risk by adult and children's services; professional decision-making impacted by affluence and status of family ; management of contact arrangement unclear; ineffective staff management and supervision processes; limited practitioner awareness of increased risk of filicide, harm to others and the risk of viewing the child as a protective factor. Makes recommendations to strengthen professionals' understanding of the negative impact of professional biases and beliefs in safeguarding practice, and to review procedures to improve understanding of the child as a protective factor, risk of filicide and harm to others in cases of adult parent or carer mental illness.

Serious case review in relation to Baby Rose *Author: Ann Duncan LSCB: Hammersmith & Fulham (2016)*

Death of "Rose", a 9-week-old baby girl, in January 2015. Rose's mother pleaded guilty to manslaughter by diminished responsibility. The plea was accepted following psychiatric reports and she was sentenced to remain in a mental health facility with an unlimited restriction order. Rose's body has never been found. Mother received antenatal services from her GP and maternity services until the 29th week of her pregnancy. GP also referred mother to the perinatal psychiatry service but she returned to her home country to give birth before they could see her. Mother came back to the UK with Rose shortly before her death. Risks identified include: mother's anxiety and low mood related to her pregnancy; previous request to terminate the pregnancy; isolation from her family; low income; and separation from Rose's father. Findings include: communication across and between health services and professionals was fragmented. Professionals did not fully understand procedures for making referrals and the geographical areas covered by the C&WH midwifery service. Recommendations include: the perinatal and maternity services must audit referrals to ensure the new system is robust and vulnerable women are identified and followed up.

Linked Research & Resources:

The National Children's Bureau (NCB) has published a report looking at progress and challenges in improving children and young people's mental health services in England, particularly for minority or vulnerable groups. Findings from an online survey of 49 professionals working with children and young people in the voluntary, community and social enterprise sector include: concerns about the system not meeting demand; respondents reported improvements in processes and structures more than improvements in access to services and outcomes for children and young people. Findings from those working with minority or vulnerable groups highlight: the need to coordinate care across a child's range of needs; appropriately differentiate mental health from other needs; personalise care based on children's particular experiences; and ensure services reach those most in need. **Source:** NCB **Date:** 30 March 2017

Neglect

Serious Case Reviews:

Serious case review: Baby W and Child Z *Author: Linda Richardson LSCB: Sunderland SCB (2016)*

Head injury to 11-week-old baby boy admitted to hospital in November 2012. The injury was later found to be a skull fracture believed to be due to a non-accidental head injury. Baby W and his 3-year-old brother Child Z were taken in to care, and later adopted. Child Z had previously been identified as a Child in Need due to concerns about neglect. Mother, who was 17-years-old when she first became a parent had been living with her grandparents, who were seen by professionals as a supportive factor. She moved into her own accommodation following the birth of Baby W. Mother had a history of: concealment of pregnancies, lack of engagement with professionals and neglectful parenting. The father was not known to any services. Issues identified include: lack of detailed awareness of Unborn Baby Procedures and their relationship to Child Protection Procedures; limitation to professionals' understanding of the impact of neglect on children's development; poor record keeping; and a lack of supportive opportunities to reflect on practice. Recommendations include: practitioners should have access to information about the tools to use in assessment; partner agencies should ensure chronologies of 'significant events' are used and maintained; and a Multi-Agency Neglect Strategy should be developed.

Serious case review: overview report: Baby N *Author: Karen Tudor LSCB: Bournemouth & Poole SCB (2016)*

Death of a 17-week-old boy in summer 2015 from "sudden unexplained death in infancy" (SUDI). Baby Nathan died whilst co-sleeping with his mother and the Coroner's report indicated overheating through being over wrapped as a contributory factor. Baby Nathan had been subject to a child protection plan due to neglect at the time of his death. Mother had been in care during her childhood and became pregnant at 16-years-old. Father had Attention Deficit Hyperactivity Disorder (ADHD), a history of drug abuse and violent behaviour and was known to the Youth Offending Service (YOS). Father's violence towards his own mother had led to two Multi Agency Risk Assessment Conferences (MARAC) before baby Nathan's birth. Maternal grandmother had a history of hoarding behaviour, leading to cluttered home conditions in which Baby Nathan slept. Issues include: contact with social workers and health professionals were problematic and a pre-birth risk assessment was not completed due to parental resistance; MARAC did not share information about father's violent behaviour with the mother; the baby's living and sleeping arrangements were not reviewed by health professionals. Learning points identified for the Local Safeguarding Children's Board (LSCB) include: the LSCB should satisfy itself that all agencies share information; protocols for the Protection of the Unborn Child need to be fully understood by practitioners; the LSCB should consider including risk of SUDI in Child Protection Planning for under ones at risk for neglect; and the LSCB should ensure clarity about health visitor's role in safeguarding babies with regard to baby's sleeping arrangements

Serious case review: Baby O *Author: Amy Weir LSCB: Sunderland SCB (2016)*

Non-accidental injuries to a six-month-old baby girl in August 2013 who was admitted to hospital a fractured femur and bruises. Mother became seriously ill following the birth and parents struggled to care for Baby O. History of: missed health appointments and poor home conditions. Baby O and her older sister were removed to the care of their paternal grandmother in May 2013. Grandmother already cared for two children under four years and struggled to look after the two siblings. Following her hospital admission in August 2013, Baby O and her sister became subject of care proceedings. Paternal grandmother was convicted of child cruelty and neglect in 2015. Mother died in 2014 from complex medical condition. Maternal history of: domestic violence; depression, non-engagement with services; and missing own health appointments. Father had history of anxiety and depression. Issues identified include: pattern of neglectful parenting not consistently monitored; threshold for Children's Services intervention was high; some positive examples of escalation but also failure to escalate and challenge inaction by Children's Services; lack of clarity about legal and safeguarding issues related to placement with grandmother; mother's vulnerability and health condition and father's involvement not sufficiently shared or considered. Recommendations include: implementation of Graded Care Profile (GCP) for interagency use in cases of neglect; regular multi-agency workshops; audit of Section 47 enquiries. Highlights some examples of good practice by professionals, in keeping the children as the central focus.

'Borough 2' Safeguarding Children Board serious case review: Child G *Author: Fergus Smith LSCB: Unnamed(2016)*

Death of a 3½-year-old African boy in November 2015. There were indications that there might have been some degree of force feeding, causing ingestion of food into the lungs. The father was found guilty of manslaughter and child cruelty. Family was known to children's services and children had previously been subject to child protection plans for neglect, physical and emotional abuse and children in need plans. Family history of: missed health, optician and speech therapy appointments and repeated attendance at accident and emergency departments due to children's injuries. Maternal history of: low level neglect; domestic violence; disguised compliance; health problems due to AIDS and missed medication. Paternal history of: physical abuse; domestic violence; refusal to attend parenting education; irregular attendance at the home as he rented another property where he stayed four nights a week. Child G's teenage step-sister had joined the family from Africa and was providing care for her step-mother and

step-siblings. Identifies findings including: lack of recognition of the impact of the mother's ill health on her parenting capacity; insufficient awareness of father's lifestyle and the reliance placed on Child G's step-sister to provide family care; parental inhibition of their children's voices; problems in information sharing following the family relocation; and professionals overlooking the needs of the children. Recommendations include: amending the Neglect Toolkit to include feeding issues and dental health; practice tool to be used by the Health Visiting Service to ensure systematic and robust information capture for new families.

Serious case review: Family HJ *Author: Nicki Pettitt LSCB: Herefordshire SCB (2016)*

Concerns of neglect and possible physical abuse of a period of five years of a minority community sibling group, with mobility, sight and learning difficulties and health challenges. Children known to children's social care and the police. Concerns around missed or cancelled appointments for weight checks and immunisations, sight and delayed development checks and lack of cooperation by the parents. Child Protection Plans were in place for some of the children as a result of neglect and one was subject to a Child in Need plan. The youngest child was briefly taken into foster care following concerns of possible sexual abuse. Care proceedings started in October 2014 were delayed by legal processes and the children were removed by the court in February 2015. Themes identified include: identification of neglect and children with disabilities; lack of cooperation by family; clarity of purpose of multi-agency meetings; consideration of each child individually; drift and changes of professionals; internal and external escalation and professional disagreements; specialist social work provision and legal processes. Recommendations include: to provide an effective multi-agency childhood neglect strategy; provision of training in culturally competent practice.

Linked Research & Resources:

Care for children with learning disabilities: The Department of Health (DoH) has published a review by Dame Christine Lenehan of the care and support for children and young people with complex needs involving mental health, learning disabilities and/or autism. Recommendations include: Local Authorities should establish how to support children and young people from their area that are placed in inpatient settings outside their area, in order to ensure that there is clear accountability for these children and young people and that they are adequately safeguarded and supported.

Source: DoH **Date:** 26 January 2017 **Further information:** These are our children (PDF)

Childhood neglect and abuse: evidence review: The Department for Education (DfE) has published an evidence review examining the effects of abuse and neglect on children, and whether different placement types affect their outcomes. Findings from the review of UK research from 2000 to 2016 includes: neglect is the most prevalent form of maltreatment; providing earlier, effective and holistic support to parents, whilst keeping the child's welfare in mind, can reduce the risk of maltreatment; the age of the child at entry to care has been consistently found to be associated with the stability of placements and children's well-being; positive changes to the caregiving environment can help children to recover from their experiences of maltreatment; children and young people may also need specialist therapeutic support to help them recover from adverse impacts of maltreatment and to make sense of their experiences. **Source:** DfE **Date:** 27 March 2017

Further information: The impacts of abuse and neglect on children; and comparison of different placement options: evidence review (PDF)

Rethinking 'did not attend': Nottingham City Safeguarding Children Board has produced a short video animation to encourage practitioners to identify children as 'Was Not Brought' as opposed to 'Did Not Attend' (DNA) when referring to them not being presented at medical appointments. The NSPCC thematic briefing on learning from case reviews for the health sector finds that the DNA category does not recognise the real issue which is children not being taken to appointments, a potential indicator of neglect.

Source: Nottingham City Safeguarding Children Board **Date:** 09 March 2017 **Further information:** Rethinking 'Did not attend' (YouTube)

Harmful Sexual Behaviour

Serious Case Reviews:

Serious case review: Child N *Author & LSCB Unnamed (2016)*

The harmful sexual behaviour of a 16-year-old child. Child N was briefly made subject to a children in need plan following two allegations of child sexual abuse. The second allegation led to Child N's conviction and imprisonment for the sexual assault of an under 13-year-old. Child N had a history of: disrupted education due to difficulties in concentration and attainment; diagnosis of Attention Deficit Disorder (ADHD) ; Statement of Special Educational Needs; concerns about inappropriate sexual behaviour and going missing from home. Identifies significant learning about responding to children at risk of sexually harmful behaviour, including: a lack of supervision for vulnerable children using shared school transport; interviewing child witnesses was not a shared agency activity; lack of shared assessment of risk and response; health care staff involved with Child N were not informed of the

sexual assault allegations; outcome of assessment overly influenced by view of positive parenting by the mother and not focused on the key risk issues; lack of policy and procedures to guide children's social care professionals; limited professional understanding of sexually harmful behaviour. Recommendations include: ensure that multi-agency practitioners are better equipped to work as part of a multi-agency approach in cases of harmful sexual behaviour; make sure early indicators of sexually harmful behaviour are recorded and shared across education settings; review the risk and safety for children who use local authority school transport.

Linked Research & Resources:

Harmful Sexual Behaviour: Summary of risk factors and learning for improved practice around harmful sexual behaviour (HSB): HSB has been a risk factor in several recent Serious Case Reviews. The reviews all point to the fact that professionals can find it difficult to respond to the safeguarding implications of HSB. There may be several children involved, each of whom will have different needs, and minimising the immediate effects of an incident can become a priority. Because of this, professionals can find themselves managing individual episodes rather than looking at the bigger picture.

The learning from these reviews and indicators of risk can be found in the following report published February 2017. https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/harmful-sexual-behaviour/

Indecent images of children: guidance for young people: The Home Office has published guidance to help young people understand the law on making or sharing indecent images of children. The guidance includes: definitions of some of the terms used in legislation; examples of situations covered by the law; three short films highlighting the harm that viewing indecent images of children can cause.

Source: Home Office **Date:** 29 March 2017 **Further information:** Indecent images of children: guidance for young people

Sexual Abuse

Serious Case Reviews:

Serious case review 'Claire' *Author: Bridget Griffin LSCB: Croydon SCB (2017)*

Review of the responses of agencies between 1 January 2012 and 31 January 2014 to a young girl who was found to have contracted two sexually transmitted infections whilst in local authority foster care. "Claire" was known to multi-agency services from the age of five months, and had previously been the subject of a child protection plan. At six-years-old she was sexually abused by a member of the household and became a looked after child (LAC) in the care of her paternal grandmother. This placement broke down and Claire was placed in foster care. The female foster carer raised concerns about her ability to care for Claire, after which the male foster carer became Claire's main carer. Claire was removed from the placement after 15 months, when she was diagnosed with chlamydia and gonorrhoea. Issues include: lack of assessment, support and guidance for kinship foster carers; absence of scrutiny and challenge when assessing and approving new foster carers; lack of collaboration between social workers representing different teams within the LAC service; the importance placed on performance indicators compromised the role of the Independent Reviewing Officer.

Linked Research & Resources:

Child sexual abuse prevention toolkit: The Lucy Faithfull Foundation has published a free online toolkit to help prevent children and young people from being sexually abused. Eradicating child sexual abuse (ECSA) is designed be used in any part of the world, and enables professionals to: understand child sexual abuse; see solutions that others have used around the world; design a local plan that fits their needs.

Source: Lucy Faithfull Foundation **Date:** 08 February 2017 **Further information**: Welcome to the ECSA toolkit (PDF)

Importance of context in assessment, intervention and prevention of child sexual abuse: The NSPCC's Impact and evidence series features a blog by Dr Carlene Firmin, Senior Research Fellow, University of Bedfordshire about the importance of context in assessment, intervention and prevention of child sexual abuse. Key issues include: the relationship a child has with the person or people who abused them; cultural norms in different environments; the legacy of space and culture of blame; and encouraging peer groups to challenge harmful behaviour, creating a safe peer environment.

Source: NSPCC **Date:** 20 February 2017

New offence of sexual communication with a child: The Justice Secretary Elizabeth Truss, has announced that a new offence of sexual communication with a child will come into effect on 3 April 2017. The offence will cover both online and offline communication, including through social media, e-mail, and letters, with adult groomers facing up to two years in prison and being automatically placed on the sex offenders register. **Source:** Ministry of Justice **Date:** 19 March 2017

Child sexual exploitation: definition and guidance: The Department for Education (DfE) has published a definition of child sexual exploitation (CSE) and a guide for practitioners and managers. The DfE has published annexes to the guidance. Annex A covers adolescent development and includes: transitions; relationships; key risks and responses. Annex B is a guide to disruption orders and legislation setting out examples of disruption measures, civil powers and criminal offences which may be used by practitioners. The government response to a consultation on revising the definition of child sexual exploitation has also been published.

Source: DfE **Date:** 16 February 2017 **Further information:** Child sexual exploitation: definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (PDF) Child sexual exploitation: annexes to definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (PDF) Definition of child sexual exploitation: government consultation response (PDF)

Substance Misuse

Serious Case Reviews:

Serious case review: Baby E *Author: Linda Richardson & Jan Grey LSCB: Sunderland SCB (2016)*

Death of a 4-month-old girl in September 2013 whilst sleeping in her parents' bed. The Inquest concluded there was no evidence that drugs caused or contributed to the death and the medical cause was recorded as unascertained. Parents were convicted of Child Cruelty and received a six month custodial sentence suspended for two years. Family had been referred to children's services by health professionals and the police due to concerns around parental substance misuse and the behaviour of the two eldest siblings. Initial assessments were undertaken, but did not result in any child protection intervention. Mother had a history of: non-engagement with professionals, substance misuse and a violent relationship with the father of her first three children. The role the mother's new partner, the father of Baby E, played in her children's lives had not been assessed by professionals. Identifies findings, including: failure to engage effectively with fathers or significant males; concerns not given high enough priority; professionals were too parent-focused and wishes of older children were not considered; lack of multi-agency collaboration and risk assessment tools; and conflicting professional views about the impact of illegal substances on parenting capacity.

Linked Research & Resources:

Rise in drug and alcohol related reports: The NSPCC highlights statistics which show that the number of contacts to the NSPCC helpline that raised concerns of substance abuse near children has increased by 16% since 2013/14 with 8,500 people from across the UK contacting the charity last year. The figures mark the start of Children of Alcoholics Week (12-18 February), which aims to raise awareness of the problems and suffering associated with parental alcohol problems. **Source:** NSPCC

Date: 13 February 2017 **Further information:** Children of Alcoholics Week

Looked After Children

Serious Case Reviews:

James: serious case review *Author: James Byford LSCB: Thurrock SCB (2016)*

Death of a 17-year-old boy of Ghanaian heritage in July 2015 in North London. "James" was found collapsed with a sheet tied around his neck. The Coroner recorded an "Open Verdict" on his death. James was a looked after child in semi-independent accommodation, following a breakdown in relationships with his family. He was known to the police and children's services in a number of local authorities. James had a history of: running away; violent and criminal behaviour; sporadic school attendance; non-engagement with services; drug misuse; self-reported mental health issues and suspected involvement in gangs. Issues identified include: looked after child (LAC) placements situated too close to areas where gangs operate; incomplete mental health assessments; insufficient work by professionals on understanding family dynamics and rebuilding family relationships and the absence of a positive action plans in response to concerns raised in LAC reviews. Examples of good practice include: James was listened to, efforts were made to engage him and he was supported regarding his court appearances. Recommendations include: review safeguarding arrangements for children in custody and young people presenting as homeless; widen the remit of looked after children inspections nationally to include semi-independent placements; embed a more robust record keeping and follow-up process for health assessments; assess the risk posed by any condition disclosed by a child or young person in custody to a forensic medical examiner and develop a matrix for identifying and escalating concerns about children in care.

Linked Research & Resources:

Special guardianship: statutory guidance update: The Department for Education (DfE) has updated the statutory guidance on the special guardianship services local authorities need to provide in accordance with the Children Act 1989. The updated document includes more information on support for special guardians.

Source: DfE **Date**: 26 January 2017 **Further information:** Special guardianship guidance (PDF)

Using technology to help young people in care: The Department for Education (DfE) has published an evaluation of seven new technologies with the potential to support young people in care. Findings show that the two most popular technologies with young people and carers were: a virtual flat that teaches young people the skills they need to move into independence; and an online platform where information could to be collated and shared between young people, carers and social workers.
Source: DfE **Date:** 24 January 2017

Further information: The Learning into Practice Project Evaluation of the University of Kent's consortium project to explore how technology can support young people in care (PDF)

Young Carers

Serious Case Reviews:

Serious case review relating to Child AA *Author: Ruby Parry LSCB: Surrey SCB (2016)*

Serious, non-accidental head injuries to a 10-week-old baby, Child AA, whilst in the care of parents. The parents were arrested and bailed pending further investigation and Child AA and an older sibling were taken into care. Sibling was subject to a Child in Need plan which continued following Child AA's birth. Team around the child and professionals meetings were also convened following Child AA's birth. Concerns about the family included: young age and immaturity of parents; lack of support from family or friends; dependence on professionals for money, food and equipment for the children; poor living conditions. Mother was a young carer for her mother, was subject to a Child in Need plan and received services from CAMHS. Issues identified include: the differences of opinion between children's social care and the community health services, which were compounded by a lack of clear and current assessment and co-ordinated planning. Recommendations include: guidance for social workers on assessment should include joint visiting with other professionals to share perceptions and views; risks to new born babies should be fully understood with the expertise of community health professionals in this area acknowledged; inclusion criteria for the Family Nurse Partnership should be revised to include young parents who have a second or subsequent child.

Linked Research & Resources:

Young carers: Carers Trust reports on the potential of young carers in the UK to fulfil their ambitions. Findings from a survey of 302 young carers include: 53% have problems in coping with schoolwork; nearly 60% struggle to meet deadlines; 73% reported having to take time out of school or learning specifically to care for a family member.
Source: Carers Trust **Date:** 26 January 2017

Childline launches counselling app: Childline has launched a new app providing counselling to young people in the UK and Channel Islands through their smartphone. The app, named 'For Me' and invented by four teenagers, allows users to interact with all Childline's online services including: 1-2-1 chat with a counsellor; the 'Ask Sam' problem pages; and entrance to their private 'locker', an area where they have their own daily mood tracker and can write down personal thoughts.
Source: NSPCC **Date:** 16 March 2017